COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

NAME:	REG.NO.:
SOCIAL SECURITY NO.:	BIRTHDATE:

INSURANCE INFORMATION

☐ PATIENT DOES NOT HAVE MEDICAL INSURANCE COVERAGE
☐ PATIENT HAS MEDICAL INSURANCE COVERAGE AS INDICATED BELOW

Please provide information even though benefits may presently be exhausted at this time

COMMERCIAL INSURANCE		
Insurance Company:		
Policy/Contract Number:		
Group Name and Number:		
Policyholder Name:		
Employer:		
Employer Telephone:		
Insurance Co. Address: Telephone No.:		
CHAMPUS		
Sponsor's Name & Rank:		
Active__Retired__Deceased__		
Sponsor's Address: Telephone No.:		
Patient I.D. Card No.:		
Effective Date:	Issue Date:	Expiration Date:
MEDICARE		
Medicare No.:		
Effective Date:	Part A:	Part B:
MEDICAID		
Medicaid No.:	County/City:	
Effective Date (if known)		
LIFE INSURANCE		
	Yes:	No:
Name of Company	Policy Number	Face Value

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PATIENT INFORMATION

Has a Committee, Trustee or Guardian been appointed by the court to manage the patient's estate? Yes___No___

Name of Person Appointed: _____ Address:_____

Date Appointed:_____Court Where Appointed:_____

Has patient served in the Armed Forces? Yes_____No_____ Branch of Service: _____

Date Served: _____ Type of Discharge: _____

Provide information below for parents, children, and spouse of patient, if applicable

Spouse Name: Spouse SSN:

Name	Address	Relationship	Age	Phone No.

List all persons who live in the same household as patient and indicate if patient and/or spouse supports

Name	Relationship	Income	Dependent	If Employed, Where?

EMPLOYMENT

☐ PATIENT IS NOT EMPLOYED ☐ RETIRED

Name of last employer:_____ Date last worked: _____

☐ PATIENT IS CURRENTLY EMPLOYED AT:

Employer: Position:
Address:
Telephone No:

IF SPOUSE OF PATIENT, LIST EMPLOYER AND ADDRESS OR INDICATE IF UNEMPLOYED

IF PATIENT IS RECEIVING SOCIAL SECURITY DISABILITY OR SSI, LIST PAYEE OF BENEFIT IF OTHER THAN PATIENT:

Benefit P Claim #:_____ Social Security No. of Payee: _____

A DISABLED CHILD MAY BE ENTITLED TO RECEIVE SOCIAL SECURITY/CIVIL SERVICE BENEFITS FROM A PARENT'S RECORD:

Social Security No. of: FATHER _____ LIVING: yes__no__ TYPE OF BENEFIT: Old Age__Disability__No Benefit__

Date of Birth: _____ Date of Death: _____

MOTHER _____ LIVING: yes__no__ TYPE OF BENEFIT: Old Age__Disability__No Benefit__

Date of Birth: _____ Date of Death: _____

PARENT'S FEDERAL EMPLOYMENT DATES: _____ AGENCY: _____

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THIS INFORMATION WILL BE FURNISHED TO MEDICAID TECHNICIANS AND WILL BE HELD STRICTLY CONFIDENTIAL!!

MONTHLY INCOME

SOURCE	PATIENT	SPOUSE	OTHER PERSONS IN HOUSEHOLD - NAME	
Salary, gross	$	$	$	
Salary, net after taxes				
Social Security				
Civil Service				
Veterans Income				
Welfare				
Retirement				
Interest/Dividends				
Rental Income				
Unemployment Benefits				
Workman's Comp				
SSI				
Other:				
TOTAL				

MONTHLY EXPENSES

Rent	$	Life Insurance	$
Mortgage	$	Health Insurance	$
Electricity	$	Property Insurance	$
Gas	$	Auto Insurance	$
Water/Sewer	$	Real Estate Taxes	$
Telephone	$	Personal Prop. Taxes	$
Food	$	Other	$

OTHER MONTHLY DEBT/TIME PAYMENTS

PAYABLE TO:	BALANCE DUE	MONTHLY PAYMENT AMOUNT
	$	$
TOTAL MONTHLY EXPENSES $		

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ASSETS (Please list present value, if any)

Checking Account/s	$	Bonds	$
Savings Account/s	$	Interest in Estates	$
Stocks	$	Interest in Trusts	$
IRAs	$	CDs	$

Name and address of bank(s) where accounts located: NAME	ADDRESS	TYPE ACCT. ACCT. NO.	OWNER NAME

PERSONAL PROPERTY **Please list all vehicles, boats, mobile homes, motor homes, motorcycles or other items subject to Virginia's Personal Property Taxes**

ITEM	VALUE	BALANCE OWED
		$

REAL ESTATE PROPERTY (directly owned or estate interest)

Location: City/County:	Address:
Description:	
Balance Owed:	Assessed Value:
Other Property:	

If you need additional space to provide any information, list on a separate sheet of paper and attach

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DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

NAME:
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I CERTIFY THIS IS A TRUE STATEMENT OF THE PATIENT'S FINANCIAL CIRCUMSTANCES TO THE BEST OF MY KNOWLEDGE AND BELIEF

SIGNED: _____ **DATE:** _____

ONLY IF YOU RECEIVE OR MANAGE BENEFITS FOR THE PATIENT, OR ARE A SPOUSE OF PATIENT SHOULD YOU SIGN THIS SECTION

****

I agree to pay the Department of Mental Health, Mental Retardation and Substance Abuse Services the sum of $_____ PER DAY for the care, treatment and maintenance furnished the patient.

This agreement is subject to the approval of the department based upon a review of the financial information you furnish. It does not prohibit the department from collecting additional sums from any other sources (such as Medicaid, Medicare, or insurance) that may be available. Payments from all sources shall not exceed the cost of providing services. Either party may request a re-evaluation any time there is a change in ability to pay or a change in authorized charges.

Payments on billing statements are due and payable in full each month unless special arrangements are made for monthly installment payments.

Payments will be from: (1) My personal resources _____

(2) Patient's resources under my control _____

I CERTIFY THIS IS A TRUE STATEMENT OF THE PATIENT'S FINANCIAL CIRCUMSTANCES TO THE BEST OF MY KNOWLEDGE AND BELIEF AND I AGREE TO PAY THE AMOUNT ENTERED ABOVE IF THIS OFFER IS ACCEPTED BY THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES.

SIGNED: _____ **DATE:** _____

*****THANK YOU FOR YOUR TIME AND ASSISTANCE*****

PENALTY FOR FAILURE TO RETURN THIS FORM PROPERLY COMPLETED

Section 37.1-118 of the Code of Virginia provides that the Department may collect from the addressee of this form a penalty of five dollars per week for each week in excess of a thirty day period that this form is not returned, properly completed.